INCORPORATING ROUTINE SCREENING FOR HISTORY OF CHILDHOOD SEXUAL ABUSE INTO WELL-WOMAN AND MATERNITY CARE

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ABSTRACT

Despite a rapid expansion in the understanding of the incidence and effects of childhood sexual abuse in the mental health disciplines, health care disciplines have only begun to look at the effect of an abuse history on women's health. Little is known from research about its influence on a woman's gynecology care or childbearing experience. The literature across disciplines advocates for routine screening for history of childhood sexual abuse. Asking about childhood sexual abuse will benefit women who have been abused and will help build a database from which to gain clinical knowledge about their care. This review presents clinical reasons to screen, discusses barriers and benefits, and emphasizes manageable ways to incorporate asking about childhood sexual abuse into practice.

Over the last decade, many articles and presentations have drawn our attention to the impact of childhood sexual abuse on women's health (1–18). Repeatedly, the literature in health care disciplines has advocated routine screening for past and current abuse (1–3, 5, 12, 14, 18–20). The arguments for having health care providers screen for history of childhood sexual abuse parallel arguments in the mental health literature also urging psychotherapists to screen their clients (21–25). Research and clinical experience, as will be discussed, show that the problem is widespread and that many of our clients' presenting problems or difficulties in the childbearing year may stem from prior abuse. Prognosis for improvement in physical and psychological well-being is poor if we do not know the cause of the problem. Still, many providers hesitate to ask women if they have ever been abused. A review of the literature indicates how asking about a history of childhood sexual abuse is clinically important, examines barriers to asking, reassures us that it surely is better to ask than not to ask, and suggests manageable approaches to including such content in the visit.

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CLINICAL REASONS TO SCREEN

Epidemiological studies suggest that between 15% and 38% of women in the general population have had unwanted sexual contact before 18 years of age (1, 26–28). Research on the sequelae of abuse shows a constellation of long-term effects that vary in prevalence and in severity. Mental health problems include depression, anxiety, low self-esteem, repeated victimization, self-destructive behavior, substance abuse, sexual dysfunction, difficulties in intimate relationships, difficulties trusting, chronic tension, eating disorders, and symptoms of post-traumatic stress disorder (21–23, 29–31). Physical problems include chronic headaches, pelvic pain, dyspareunia, vaginismus, urogenital or gastrointestinal complaints, sleep disorders, and possibly severe premenstrual syndrome (1, 4, 19, 32, 33). Abusive sexual contact that involves penetration can cause tissue damage and scarring, infection, and pregnancy, thus increasing gynecological risk factors.

Researchers and providers have

0091-2182/95/$9.50 • 0091-2182(94)00085-K

only began to explore the impact of past abuse on body image, self-care, and the woman's experience of pregnancy, labor and birth, breast-feeding, postpartum depression, and adaptation to motherhood (2, 4–6, 15–17, 34, 35).

There is anecdotal evidence and recent research to verify that a woman with a history of childhood sexual abuse may experience physical exams and diagnostic or treatment procedures as intrusive and traumatic. She may avoid routine gynecological exams and needed care. She also may fear (or it may have been her experience in the past) that exams or procedures, birth, or breast-feeding will trigger flashbacks or body memories or that she will lose control and be embarrassed (2, 4, 5, 7–9, 12, 15, 34, 36). The power dynamics and other aspects of her labor and birth experience may parallel those of an abusive relationship (10, 16). For example, she may feel unable to object to the actions of a provider whose interpersonal style is authoritarian or "fatherly." Being told to "just relax" or "stop making so much noise" in childbirth may trigger memories of similar commands during an episode of abuse. Being exposed or having unwelcome people present may reenact her vulnerability and inability to protect herself. The pain of birth itself or of initiating breast-feeding may feel like pain from abusive sexual contact.

Without knowledge of a history of abuse, we may observe these problems but we will overlook their cause, and we will miss opportunities for appropriate treatment and healing. If we know that the client has been abused, we can increase her comfort, control, and power by asking her how we can adapt our practice to meet her needs. This way, our care will not be traumatic to her or a re-enactment of abuse and may, in fact, decrease her alienation from her body (7). (Holz [5] outlines ways to approach a well-woman visit with a survivor.) The long-term relationship formed for maternity care provides an opportunity to mutually develop a plan of care for the childbearing year. Such a plan needs to address special needs the pregnant woman may have for labor support and parenting support, and it needs to provide her with time to talk about her feelings all along the way. Finally, if we know that she has been abused, we should ask if she needs a psychological counseling referral to facilitate her recovery. During the emotionally charged childbearing year, she may especially benefit from the knowledgeable support of a therapist who treats survivors (1, 4, 15). This psychologist or social worker can also be a valuable resource person for the nurse-midwife.

BARRIERS TO SCREENING

Given the number of women with this history and the potential impact of abuse on their health, it is surprising that more women's health providers do not include questions about sexual abuse in their history taking. There are many possible explanations for why routine, universal screening has not been incorporated more widely into practice. The myth that childhood sexual abuse is rare persists despite evidence to the contrary (23, 27, 28, 30, 37–39). Many would argue that not only the act, but discussion about sexual abuse is taboo (25, 40, 41). It is a disturbing phenomenon that many clinicians find awkward to approach in a matter-of-fact way. The incidence of history of childhood sexual abuse among helping professionals—including nurses and physicians—may be higher than in the general population, which means that nearly half of us may be burdened with long-term effects of our own that we may fear bringing to the discussion (42). We may be concerned that asking will provoke an emotional response that we are not prepared to manage. Nevertheless, there are many clinical reasons why we should ask about prior abuse. There are also abundant statements in the literature that should encourage and support our efforts to incorporate this assessment into practice.

SUPPORT FOR SCREENING

The feminist psychiatrist Judith Herman (23) reassures us: "Asking about incest is like asking about any other taboo subject, such as alcoholism, violence, or suicide. If the [clinician] is reasonably comfortable posing the question, the patient will be comfortable answering it." Several studies that evaluated subjects' response to being questioned for research purposes assure us that the majority of survivors do not mind being asked (19, 39, 41). Felitti's primary care screening study (19) revealed that more than 90% of the participants who had been abused had never been asked before. Only 3% of the abused participants responded angrily about being asked. Of Russell's (39) 152 research subjects who had experienced incestuous abuse, 64% were judged by the interviewers to be "very willing" to disclose their experiences, 33% "will-

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ing," and only 3% "unwilling." When asked how comfortable they felt answering the questions, 51% of the subjects answered "very comfortable," 27% answered "somewhat comfortable," and 6% "very uncomfortable."

A recent study by Robohm and Buttenheim (12) looked specifically at the issue of survivor disclosure to gynecology providers. Among the 44 survivor and 30 nonabused respondents who answered survey items about their experiences of disclosure, 84% said they had never been asked about a history of sexual abuse or assault by any gynecology care provider. When asked if they think that providers should ask, 93% of the survivors and 96% of the nonabused respondents said "yes" or "it depends," and 65% of the survivors gave an unqualified "yes."

It may boost our resolve to take the risk and ask if we realize that, far from harming the woman—and aside from any improvement in her experience of our care—merely asking the question may help her. Lister (25) addresses the traumagenic effect of the secrecy of childhood sexual abuse and states that giving permission to break the secrecy can be a powerful intervention and an aid to healing. As Herman stated in her classic book, *Father-Daughter Incest* (23), "Direct questioning can be a great boon to patients who are troubled by their incest experience but who do not dare to raise the issue themselves. Over and over we have heard the testimony of victims who longed for the opportunity to talk about their experiences with a helping person and who waited in vain to be asked."

Many women who have been sexually abused are strong, have well-developed coping mechanisms, and may have benefited from some measure of healing (43). Others may suffer from a range of psychological sequelae, all the way from multiple personality disorder to addiction to compulsive overachievement. Anticipating a gynecological exam may not cause a survivor any more concern than it causes anyone else. On the other hand, it may cause her a range of feelings, from mild concern about how the nurse-midwife will treat her, to worrying about how she will tolerate the exam, to anxiety bordering on a panic attack. When asked about sexual abuse, the survivor might answer that she has an abuse history but that it does not cause any major problems for her now. Or the nurse-midwife might encounter a fragile woman already experiencing considerable anxiety who becomes upset.

Evoking a strong emotional response to the screening question might seem like the worst thing that could happen. But, it is not. It would be worse not to ask and to proceed with an exam that itself may cause a strong response.

With the history information, the nurse-midwife can provide emotional support and address the woman's particular concerns. If the exam is difficult for her, at least both people know what is going on. Problem-solving is focused on how to help rather than on trying to figure out what the problem is.

Without the history information, the emotional impact of the exam on the woman may be evident, but it will be more difficult for the nurse-midwife to respond appropriately if she or he does not know the reason for the reaction. The emotional impact of the exam also may not be evident. It may happen more frequently than we know that the woman will suffer the feelings without any obvious affect, and the nurse-midwife will never be aware (12). At best, it will have been a missed opportunity for care, mutual satisfaction, and healing. At worst, it will have been a trigger for anger, anxiety, and manifestations of post-traumatic stress and a retraumatization (7–9, 17, 36). Asking the question communicates therapeutic messages: She is not the only one. We are open to knowing about her experience and its impact.

APPROACHES TO ASKING

In Robohm and Buttenheim's study (12), it was found that those who had been abused wanted to be asked, but only if certain conditions were met. They expressed concerns that the information be confidential, that they be asked while they were still fully clothed, and that the provider be "sensitive and knowledgeable about sexual abuse and its effects." Many of the survivor respondents who felt that the question should be asked reported that they felt unable to bring up the topic themselves. Others stated that they feared that providers who did not ask could not understand their experience or would not be prepared to hear about their experience.

Of course, the screening question may lead to more than a "yes" or "no" answer. We need to be willing to show acceptance and empathy as we listen. The situation may indicate that further assessment would be appropriate. It is useful to see that in Courtois' initial 1980 study (41), in which survivors discussed the abuse in some detail, the women indicated that the brief opportunity to talk about their history was therapeutic.

We may have concerns that the scheduling constraints for gynecology appointments do not allow for time to talk about this issue. Certainly, on any given day, we may not feel emotionally available to deal with this information empathetically. Even with these constraints, it is still possible to ask questions in a way that balances the needs of the client and the caregiver. One way to do this is to frame the question so that it limits the response to the context of the gynecology exam, for example, "Is there anything about your past expe-

riences that makes this exam particularly difficult for you?" with a follow-up question, "What can I do to make it easier for you?" (Robohm JS, personal communication). We may need to offer to schedule an additional appointment in order to have enough time for someone who really needs to talk about her concerns before being examined. A more open-ended question can be reserved for circumstances in which we are likely to have an on-going relationship with the woman and in which the impact of childhood sexual abuse will need to be explored in more depth, such as at an initial prenatal visit. In this context, there is usually more time to devote to listening to how the woman thinks her history may affect her pregnancy and our care for her.

The screening question may also lead to a "no" answer from a woman who indeed was abused. She may be unaware of her history because she is among the survivors of abuse who repressed knowledge of the events in order to cope (30, 31, 44, 45). Even if she is aware of prior abuse, she may not trust yet or feel prepared to reveal such a personal matter at that moment, but she may bring it up again later (1, 3). At least, she knows that her nurse-midwife is approachable and willing to listen.

Finally, we need not reinvent the wheel if this line of questioning is new to us. Several authors outline explicit but nonthreatening wording for screening questions (5, 43, 46). "Were you ever sexually abused as a child?" is one simple way to ask. However, some women will not equate what happened to them with the societal label "sexual abuse" (let alone "incest"). A question that focuses on her perception may be better. For example, "Did you have any unwanted sexual experiences when you were a child?" Each of us will need to try a few different scripts for asking until we find one that is appropriate and comfortable. Although a written question on an intake history form might seem less threatening, face-to-face inquiry by a supportive person seems to yield the greatest percentage of positive responses (14, 26, 39, 47). Some woman have concerns about having this sensitive information in writing in their records. Others need to meet the provider and form some judgment of the provider's ability to empathize before disclosing their history (12). Large services may want to expand their working knowledge through journal discussions or in-service programs and to include the subject in chart reviews as part of the peer-review process. Individually, we can also take advantage of networking relationships with therapists who treat survivors to ask for suggestions—or we can use the quest for suggestions as an impetus to network with therapists in order to develop our referral resources.

THE IMPLICATIONS OF ASKING

As we change our practice by actively seeking to learn if our clients have been abused, we may fear that this knowledge will cast a cloud over our work, that we will lose our positive orientation to the childbearing woman. In fact, it is likely that we have already encountered survivors in our practice and have been at least dimly aware of these women's trauma. By seeking to know for sure, we will gain the opportunity to provide more empowering, respectful, holistic, and clinically on-target care. We will have the privilege of helping the survivor take steps toward improving her physical and psychological health for the rest of her life. In turn, her increased well-being can only improve the well-being of her family of creation. Last, but certainly not least, by breaking the taboo of silence about childhood sexual abuse, we are contributing to the work of stopping abuse from happening so that childhood will be safer, and women will be given the opportunity to be stronger and healthier.

The authors wish to acknowledge Jennifer Robohm, MA, and Margaret Butterheim, PhD, of the University of Michigan Department of Clinical Psychology for sharing their research, for their advocacy on behalf of the gynecology health care needs of survivors, and for their encouragement related to this review. We would like to express appreciation to Alice Brunner, PhD, and also to Jane Hassinger, MSW, of the Interdisciplinary Project in Feminist Practice at the University of Michigan for their contributions to the development of feminist practitioners.

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